Lack of coordination between services

The problem

In many countries where a lot of care is provided by volunteers or by international NGO's, the quality of care may be not so high. Most of the international focus groups participants reported that the inappropriate response of the authorities and the presence of different actors in combination with a lack of organization and coordination produce a chaotic setting that has very bad consequences. Refugees receive differing and confused information about health care services so that they can't understand how to behave within such a complicated system. This is connected with the issue of lack of information for refugees but also with the problem of the circulation of information and health data between different institutions at different levels. Poor management of the refugee crisis in health care and lack of coordination between the different health providers, cause overcrowding in hospitals that could be avoided with better organization. This situation may also lead to care providers working with refugees suffering from burnout syndrome and compassion fatigue (see organisational barrier if there is repetition).

Evidence on the barrier

Many studies indicate that limitations in providing health care to patients is a result of chaotic organization and a lack of cooperation and integration between different agencies (Governmental and NGO); in certain countries a specific actor for coordinating this activity is not even identified. The abundance and variety of service providers can, in itself, cause problems as the complex relationships between organisations can lead to confusion for refugees. (Qayyum, Thompson, Kennan, & Lloyd, 2014)

Lack of cooperation between health care providers can also lead to dysfunctions and confusion in service delivery. Focus group participants mentioned that there are a large number of different health professionals and volunteers working in health care services. The variety of random workers with different professions, backgrounds, work attitudes, knowledge and skills (the majority with no previous training in the field of migration and health) also creates great challenge to health care coordination. In this situation, where there are new health care workers on the spot every day, consistent team work is almost impossible, the working process was reported to be harder to organize, and having control over it was felt to be unimaginable. The current gap in coordination between different care providers not only creates confusion in the division of roles, but also produces a waste of human and financial resources (International Organization for Migration, 2015b).

Lack of collaboration between social and health services hinders the identification of effective solutions to improve the living conditions and health of the refugees. Refugees were reported to rely on health care services to solve a number of problems that are clearly situated in the social domain. Issues of housing and administrative problems are often presented to health care providers as they seem to be the single point of contact with the host society.

Lack of policy coordination is another important challenge because it is strictly linked with the possibility to access to health care (Ignacio Correa-Velez*1, 2005): in many cases there is no coordination model in place that defines roles and responsibilities of the major stakeholders in taking care of refugees. This is also a very complex issue because there are multiple elements to coordination: participants, coordination structures, budgeting and money flows, and information

Lack of coordination between different sectors (legal, employment, shelter, water and sanitation, health, social and education sectors..) is a consequence of the previous point and it causes difficulties in implementing inter-sectorial interventions that are more efficient and can reduce the waste of resources. For example, various obstacles to more active cooperation between public health and law enforcement

authorities result in back and forth transfer of responsibilities without much getting done. At the same time local hospitals are unable to keep up with demand as they are in fact the only officially sanctioned health care service available to migrants. Doctors reported difficulties in obtaining accurate and timely medical information on migrants from NGO and others previous care providers (International Organization for Migration, 2015a).

Measures to address the barrier

Both research and experience in the field highlight that a partnership with a wide range of actors, especially government, UN and international agencies, non-governmental organisations, academic institutions and the private sector is necessary to ensure the availability of quality public health services for refugees.(UNHCR, 2011) Since coordination of care between multiple providers and services has the aim of achieving improved quality of care for patients, the first step is to improve formal access and ensure entitlement to access to services for all groups of migrants throughout the different phases of the migration trajectory in a common and coherent way.

An integrated approach to policy development, planning and to the delivery of services is an effective solution to improve coordination of services both between agencies and vertically throughout the various levels of government (Feldman, 2006). This coordination begins at the planning stages of service delivery, in particular, there is a need for structured coordination of health and social welfare services for the resettlement of refugees in regional and rural areas (Duncan, 2007). One study (McDonald, Gifford, Webster, Wiseman, & Casey, 2008) recommends the development of a 'well-planned, well-integrated and well-resourced' approach which aims at long-term sustainability of refugee communities. A factor that is critical for success is the establishment of a coordinating agency, for instance local government as a lead coordinating agency (Qayyum et al., 2014).

Shared and horizontal protocols involving multiple sectors and levels ensure coordination and quality of care (International Organization for Migration, 2015a). This measure makes it possible to define specific agency roles and responsibilities during the entire reception process. For example, close coordination between education and training services and employment services, and between refugee health and community services, along with "well-defined referral pathways can yield multiple beneficial results, including cost savings" (McDonald et al., 2008, p. 57).

The creation of a network for the exchange of information and good practice between all structures and services working with migrants improves the collaboration between health care workers of different agencies. The first step is to be aware of all other actors involved in providing care to refugees, for example by maintaining a shared list of all health care providers, as volunteers keep changing and doctors do not know the people in the different NGO's. A clear and defined communication strategy is also important to be able to connect all actors and engage them on the same mission (UNHCR, 2011)

Standardised inter-institutional operational procedures are another important measure that would ensure that health provision for migrants is incorporated into general health system planning and strategy documents at a local level (Norredam, 2016). They constitute a set of step-by-step instructions that define the roles, responsibilities, guiding principles and procedures to help organizations and workers carry out routine operations: this measure aims to improve efficiency, quality output and uniformity of performance, while reducing miscommunication and failure to comply to industry regulations.

"Technical round-tables" are another facilitating factor to create and maintain coordination and to share experiences and good practice. The exchange of information and data between different actors is a focal point to ensure coordination and continuity of care. Migrant refugees need to be involved in these discussions in order to involve migrants in the identification of barriers and solutions with the aim of better

coordinating actions. Intercultural mediators or other mediating professionals, such as community health educators, could have an important role in facilitating the discussion.

The existence of an intersectorial strategy is a key factor to guarantee coordination between sectors and actors involved in providing health care to refugees (Norredam, 2016). Moreover the development of a coordinated system of care could also mean improving communication between the different levels involved, between different institutions and between different structures and stakeholders.

Additional measures to favour coordination could be informal communication between workers or services, team meetings, case conferences with multidisciplinary team, interagency meetings, shared assessments and records, round tables with non-health services including language services (interpreters, translated health information), formal settlement services, torture and trauma services, referral pathways and inter-service agreements (Joshi et al., 2013).

Successful example

Technical roundtable
(Seville, Spain)

Service/department in charge of the measure:
Directorate General for the Coordination of Migratory Policies.

Description of the measure:
Establishment of a technical roundtable composed of healthcare counselling centres together with social organizations working with refugees.

Expected outcomes:
To identify actors involved in a possible massive reception, specifically targeting healthcare services

Achieved outcomes:
The measure was promoted by the organization and supported by the management. There is no shared opinion between the Ministries on the need to rely on the specialized organizations. Refugees' healthcare overlaps with other migrant's healthcare, and there appears to be some reluctance to take refugee issues fully on board. The lack of financial resources since 2010 is inducing a "selective attitude".

Resources needed for implementation:
Maximum involvement is stressed.

References to know more:

Duncan, G. (2007). Refugee resettlement in regional Australia. Paper presented at the 9th National Rural Health Conference.

Feldman, R. . (2006). Primary health care for refugees and asylum seekers: a review of the literature and a framework for services. . *Public Health, 120(9), 809-816*.

Ignacio Correa-Velez*1, Sandra M Gifford1 and Sara J Bice1, 2. (2005). Australian health policy on access to medical care for refugees and

asylum seekers. *Australia and New Zealand Health Policy 2005, 2:23*.

International Organization for Migration. (2015a). Greece.

International Organization for Migration. (2015b). Italy.

Joshi, C., Russell, G., Cheng, I. H., Kay, M., Pottie, K., Alston, M., . . . Harris, M. F. (2013). A narrative synthesis of the impact of primary health care delivery models for refugees in resettlement countries

on access, quality and coordination. *International Journal for Equity in Health, 12*(1). doi: 10.1186/1475-9276-12-88

McDonald, Brooke, Gifford, Sandy, Webster, Kim, Wiseman, John, & Casey, Sue. (2008). Refugee resettlement in regional and rural Victoria: impacts and policy issues. *Melbourne: Victorian Health Promotion Foundation*.

Norredam, M. (2016). *Migration and health: Organising access to EU health care systems for migrants*, Brussels, Belgium.

Qayyum, M. A., Thompson, K. M., Kennan, M. A., & Lloyd, A. (2014). The provision and sharing of information between service providers and settling refugees. *Information Research, 19*(2).

UNHCR. (2011). Ensuring Access to Health Care: Operational Guidance on Refugee Protection and Solutions in Urban Areas.